KINGSTON CITI BUS

17 HOFFMAN STREET
KINGSTON, NY 12401

PHONE (845) 331-3725
TTY (845) 331-5350
FAX (845) 331-3362

PARATRANSIT BUS
RULES & REGULATIONS
APPLICATION

Para transit Bus Rules & Regulations

The Kingston Para Transit Bus will be in operation Monday-Friday. Reservations must be made twenty-four hours in advance. There is no service on New Years Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. Fare for this bus will be $1.50 one way within the city limits. Fare outside the city limits will be $3.00 one way.
Individuals wishing to accompany the ADA rider will be allowed to ride providing the space is available and that will not result in a denial of service to another ADA eligible person. Non-ADA person will be charged the same fare as the para transit person. A personal care attendant shall not be charged a fare.

Anyone wishing to use the Para transit bus must fill out the required application. All applications will be reviewed as soon as the application is reviewed in the city bus office. Decision of acceptance or refusal will be determined in a timely manner. Anyone needing assistance in filling out this application may call the City Bus Office at (845) 331-3725, the hearing impaired may call (845) 331-5350. The City Bus Office is located at 17 Hoffman Street. You may call between the hours of 8:30am and 3:00pm for an appointment and someone will be happy to assist or answer questions. Any incomplete application will be returned, thus causing a delay in processing said application. All information will be keep confidential.

The bus will pick up at curbside. Individuals using the Para transit bus must be able to board the bus without assistance from the bus driver. Anyone needing assistance must have a personal care attendant.
Appointments must be canceled twenty-four hours in advance. No-Show Policy: Section(37.125(h)) of the regulations allows the provision of complementary Para transit service to be suspended, for a reasonable period of time, in cases where an individual consistently misses scheduled appointments. This provision does not apply to trips that are missed for reasons that are beyond the individual s control. Scheduling problems, late pickups and other operations problem must be considered beyond the rider s control. If notice is given by the rider far enough in advance to allow re-routing of the vehicle trip, this will be recorded as being canceled. Any scheduled appointment not canceled will then result in a full fare charge to the individual or sponsoring agencies. Applicant will be notified in writing of impending suspension of service. At that time a review of the application will be made to determine if said applicant should be reinstated. Service will be re-fused if a passenger becomes violent, seriously disruptive, or engages in illegal conduct (37.5(h)).

APPLICATION FOR SPECIAL SERVICE FOR TRANSIT-HANDICAPPED PERSONS

The information on this form will be used only by the City of Kingston and will not be provided to any other persons or agency. If additional space is required or an explanation please use other side and number clearly, according to questions.

Type or print clearly

1. Name of person for whom service is being applied for:

_____

2. Home address: _____

_____

Mailing address (if different): _____

_____

3 Telephone home: _____(work)_____

4.Date of birth: _____

5. What is the physical, mental, or visual condition(s), which prevents you from using a fixed route bus service?

6. How does this condition prevent you from using fixed route service? Please explain completely. Use additional paper if necessary.

7. Is there any other effect of the condition of which we should be aware?

8. Do you use any of the following aids? (check all that apply to you)

Manual Wheelchair___ Electric Wheelchair _____ Cane _____

Crutches ___ Personal Care Attendant ___ Guide Dog _____

Other (please indicate) _____

9. I hereby certify that the information given is correct and I authorize the completion of this form and release of the information to the City of Kingston Transit.

_____ _____

Signature Date

10. If someone, other than the applicant, completes this form, that person must completed the following:

Name _____

Address _____

Signature _____ Date _____

TO BE COMPLETED FOR THE PHYSICALLY HANDICAPPED PERSON

Type or print clearly

Questions 11-20 should be completed by a medical doctor, physical or occupational therapist, or rehabilitation center professional.

11 Medical diagnosis and date of handicapping condition:

12. Is this condition temporary? No ___ Yes ___

13. Is this condition likely to become worse? No ___ Yes ____

14. Is this person able to walk without the assistance of another person:

a. 200 feet? ____ No ____ Only with great difficulty __

b. _ mile? Yes ___ No ____ Only with great difficulty __

15. Is this person able to climb three 12 steps using a handrail?

a. Yes ___ No ____ Only with great difficulty _____

16. Is this person able to wait outside without support for ten minutes?

All of the time ____ Some of the time ___ Not at all ____

17. Is this person able to ride in an automobile (including getting in and out)?

All of the time ___ Some of the time ___ Not at all ___

18. Does this person require the use of the following?

a) Wheelchair

All of the time ____ Some of the time ___ Not at all __

b) Cane, crutches or walker

All of the time ____ Some of the time ___ Not at all ___

c) Prosthesis:

All of the time ____ Some of the time ___ Not at all ___

d) Guide dog

All of the time ____ Some of the time ___ Not at all ___

e) Personal care attendant

All of the time ____ Some of the time ___ Not at all ___

f) Other (describe) _____

19. Is there any other effect of the condition of which we should be aware?

Please describe.

20. The name and signature below should be that of a medical doctor,

physical or occupational therapist or rehabilitation professional.

Name _____

Office address & mailing address if different:

_____

Signature_____ Date _____

Office phone _____

TO BE COMPLERED FOR THE VISUALLY HANDICAPPED PERSON

Type or print clearly

Questions 21-27 should be answered by an ophthalmologist or rehabilitation center professional.

21. Medical diagnosis and date of handicapping condition:

22. Is this condition temporary?

No ____ Yes ____ (Expected duration until _____)

23. Is this condition likely to become worse: No ___ Yes ___

24. Visual acuity _____ Right eye ____/____ Left eye ____/___

25. Visual field: Right eye Horizontal ___ Left eye ___ Horizontal __

Vertical ___ Vertical _____

26. Is there any other effects of the condition of which we should be aware?

Please describe:

The name and signature below should be of an ophthalmologist, optometrist or rehabilitation center professional.

Name _____

Office Address _____ Phone _____

Specialty or Title and Agency _____

Signature _____Date _____

TO BE COMPLETED FOR THE MENTALLY HANDICAPPED PERSON

Type or print clearly

Questions 28-34 should be completed by a qualified medical doctor, psychiatrist, psychologist or rehabilitation center professional.

28. Medical diagnoses and date of handicapping condition.

29. How does this condition affect the individual s ability to use a fixed-route bus service?

30. Is this person able to:

a. give addresses & telephone number on request Yes ___ No __

b. recognize streets and bus numbers Yes ___ No __

c. sign his/her name Yes ___ No __

d. deal with an unexpected situation Yes ___ No __

e. ask for and understand directions Yes ___ No __

31. Is this condition:

a. subject to significant improvement with treatment Yes ___ No____

b. likely to become worse. Yes ___ No ___

32. Should this person be accompanied while using our Complementary Para transit service. Yes ___ No ___

33. Is there any other effect of the condition of which we should be aware? Please describe.

34. The name and signature should be that of a medical doctor, psychiatrist or rehabilitation center professional.

Name _____

Office address _____ Office phone _____

Specialty or Title Agency _____

Signature _____ Date _____

Notice of decision will be mailed to the individual for whom the service is being sought.

Optional: In order to assure that the disabled individual receives a determination, the City request the identification mailing address and phone number of a second individual who will also be notified of the decision

Thank you,

FOR OFFICE USE ONLY

Date Received in Office: _____

Date of staff Review for Completeness & Accuracy: _____

Date of Review: _____

Decision and Supporting Statement/Comments: _____